



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TEXAS HOSPITAL
1201 LAKE WOODLANDS DR SUITE 4024
THE WOODLANDS TX 77380

Respondent Name

Texas Mutual Insurance Co

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-3544-01

MFDR Date Received

August 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In the present matter, the Claimant was suffering from a recent onset of Patient's presenting concerns. It is reasonable to assume that this led the Claimant to believe that a delay in treatment would put him/her at risk of "serious dysfunction of any body organ or part."

Amount in Dispute: \$159.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant was in the facility less than two hours, had a physical examination, and was discharged. That simply does not meet the criteria of an emergency."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 23, 2011	Outpatient Hospital Services	\$159.15	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines an emergency.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 1, 2012

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-16 – CLAIMS/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED

- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Explanation of benefits dated June 29, 2012

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Issues

1. Does the disputed service(s) meet the definition of an emergency service?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code, 899 – “DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2”. 28 Texas Administrative Code §133.2(4)(A) states that, “a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient’s health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part.” The medical documentation does not meet the definition of an emergency pursuant to §133.2(4)(A). For example:
 - a. EMERGENCY PHYSICIAN RECORD/Low Back Pain / Injury records shows chronic back pain but with no indication of severity.

The Division concludes the denial code 899 is supported.

2. As definition of an emergency outlined in TAC Code §133.2(4)(A) is not met, no payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 6, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812